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ABSTRACT

This theoretical paper is based on the premise that nearly all people who enter therapy do so, to varying degrees, with the wish (conscious or unconscious demand) to have dependent longing and affectional needs gratified in the therapy itself. The conditions under, and the extent to which, the therapist provides direct gratification are crucial determinants of the outcome of therapy. While certain amounts and forms of direct gratification are helpful and often necessary, too much and/or certain kinds of gratification may be destructive. The paper presents five rules-of-thumb to help guide therapist decisions about when to gratify what demands. An effort is made to connect the rules to clinical theory and recent research. The rules-of-thumb focus on: (a) differentiating between patients' wants and needs; (b) a proper therapeutic stance vis-a-vis direct gratification; (c) the use of direct gratification in the early stage of therapy; (d) patient characteristics (severity of disturbance and infantilism of demands) moderating the appropriateness of direct gratification throughout the therapy. (Author)

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GRATIFICATION: A PIVOTAL POINT IN PSYCHOTHERAPY

Charles J. Gelso

Research Report # 1-77

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Summary

This theoretical paper is based on the premise that nearly all people who enter therapy do so, to varying degrees, with the wish (conscious or unconscious demand) to have dependent longing and affectional needs gratified in the therapy itself. The conditions under, and the extent to which, the therapist provides direct gratification are crucial determinants of the outcome of therapy. While certain amounts and forms of direct gratification are helpful and often necessary, too much and/or certain kinds of gratification may be destructive. The paper presents five rules-of-thumb to help guide therapist decisions about when to gratify what demands. An effort is made to connect the rules to clinical theory and recent research. The rules-of-thumb focus on: (a) differentiating between patients' wants and needs; (b) a proper therapeutic stance vis-a-vis direct gratification; (c) the use of direct gratification in the early stage of therapy; (d) patient characteristics (severity of disturbance and infantileness of demands) moderating the appropriateness of direct gratification throughout the therapy.

A revision of this paper will appear in a 1977 issue of Psychotherapy: Theory, Research and Practice.

GRATIFICATION: A PIVOTAL POINT IN PSYCHOTHERAPY

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It is the premise of this paper that the wish and indeed the demand to have dependent longings and needs for affection gratified occurs in nearly all psychotherapies.[2] That is, the patient exhibits, subtly or explicitly, demands, expectations, wishes, etc.[3] for the therapist to love and take care of him/her in the therapy situation itself. How should such feelings be treated? Apart from a few forms of therapy which posit explicit rules, little of a definitive nature is written about the conditions under which the therapist should provide direct gratification, i.e., directly show love, affection, etc. and take care of the patient.

The clearest statement on this matter exists in classical psychoanalytic theory. Freud noted very explicitly that..."Analytic treatment should be carried through as far as possible, under privation - in a state of abstinence (1919, p. 162)." The classical position is that when we give in to patients' requests for such gratification, resistances are heightened to the development of insight into the sources of these neurotic demands. Freud further stated that..."Cruel though it may sound, we must see to it that the patient's suffering, to a degree that it is in some way or other effective, does not come to an end prematurely (p. 163)."

In classical client-centered therapy, also, it seems clear that the therapist is not to gratify, at least directly, such demands. While his job is to provide a gratifying atmosphere (empathy, acceptance, respect, warmth, genuineness, etc.), the client-centered therapist's behavior consists predominantly

of reflecting and summarizing feelings, and of honestly disclosing the effect of certain patient expressions on him, i.e., especially when these expressions are obtrusive to the movement of therapy. To the extent that the "rules" are adhered to, neither the classical client-centered therapist nor the classical analyst (or analytic therapist) admits positive feelings toward the patient, attempts physically or verbally to soothe the distressed patient, gives suggestions, reassurances, etc. in response to the patient's requests or demands for such.

When we move away from these two theoretical positions, or at least strict adherence to them, the water gets muddy indeed. Therapeutic orientations such as Gestalt therapy, transactional analysis, the varieties of humanistic therapy, rational-emotive therapy, primal therapy, etc. posit no "rules" on this matter. The literatures of these "schools" appear to have ignored Freud's rule of abstinence. Yet when one scrutinizes those literatures it is usually most unclear what gets gratified, the conditions under which the above-noted needs are gratified, or even when gratification is, in fact, occurring. For example, Kopp (1973), a humanistic theoretician, tells us that his tactical rule-of-thumb in the initial stage of therapy is to "be where they ain't." Thus,... "patients who are initially too hard on themselves are to be treated gently and indulgently." This sort of strategy may reflect gratification of intense dependency needs that are protected from consciousness by patients' being "too hard on themselves."

Even within the classical analytic framework, things have never been as clear as they may have seemed. For example, in the above quote, while positing his famous rule of abstinence, Freud implied that we should abstain <u>as far as</u>

possible. Also, some of Freud's own cases (the Wolfman being a striking example) reveal intense gratification...to a point that would be considered anathema to many present day classicists. Still within the classical context, Greenson (1967) notes that some gratifications are absolutely necessary so that the painful work of analysis can proceed. Similarly, Ferenczi (1955) believed that at times we must indulge our patients so that they may tolerate the "unpleasure" of insight and working through. Further extensions of the classical position are even more dramatic (e.g., Rosen, 1962).

A Paradox

As implied, the premise of this paper is that all people who are suffering and enter therapy do so, in varying degrees, with the wish to be directly gratified (loved, taken care of) in the therapy itself. Yet if such wishes are gratified "too much", the therapy will not have durable positive effects because: (a) gratification, as suggested by the classical position, tends to impede the difficult task of acquiring deeper understanding and working through; (b) gratification tends to foster dependence on the therapy (i.e., exacerbate the impulses that it feeds) and thus impedes the crucial outcomes of separation and individuation. In effect, the patient gets sustained in the therapy itself ...he/she gets weekly, etc. shots in the arm and, as Freud worried, may exchange the wish to be cured for the wish to be treated.

Yet there are instances in each and every therapy case (including analysis) where direct gratification is appropriate, helpful, and even necessary to the continued progress of therapy. By direct gratification I mean responses beyond those usually thought of as necessary to the development of a safe, considerate, understanding climate. Some salient examples of direct gratifications are giving encouragement and reassurance, making suggestions, telling a

patient you care, allowing extra sessions, physically touching a patient. All these forms of gratification, to varying degrees, must be dispensed with caution...but nonetheless most of them are important to the success of therapy. Thus, the paradox is that while certain doses of direct gratification are helpful, at times necessary, too large a dose or too many doses or certain kinds of doses (with this or that patient) are damaging. In essence, the conditions under and the extent to which gratification occurs are crucial in determining the nature and quality of the outcome of therapy.

When to Gratify: Some Rules of Thumb

The present section of this paper will explore some central issues revolving around gratification and propose certain rules of thumb which I have found helpful in guiding decisions about when to gratify what demands. By rules of thumb I mean rules based on experience and practice rather than on scientific knowledge. When possible, I shall attempt to connect the rules to theory and research.

Needs and Wants

A first and crucial step in deciding whether to gratify a particular demand, and in formulating how gratifying to be in general in a given therapy, is to get a handle on whether the patient wants gratification or needs it. Most demands for gratification are attempts at reducing anxiety and, to a somewhat lesser extent, to eliminate genetically based sources of anxiety, e.g., to eliminate introjected bad mother objects in the case of many people suffering from schizoid disorders(cf. Guntrip, 1968, 1971; Jacobson, 1964). While the patient may want advice, an open admission that the therapist cares, etc. in order to feel better, what he/she needs is the kind of deeper understanding that teaches him/her how to get appropriate extra-therapy satisfactions (and the corrollary of this...what stops the patient from getting these).

A case that exemplifies the above points involved a therapist trainee who entered therapy with me because of repeated depressions. This person presented a picture of persistently low self esteem which manifested itself interpersonally through a tendency to withdraw, oversensitivity to rejection and strong expectations for rejection. Along with self-esteem problems, this person's character structure reflected high degrees of dependency and ambivalence so characteristic of depression prone persons (see Nemiah, 1973). In the therapy, there was a continuing struggle to obtain from me what she had always felt deprived of from mother and from others. She felt I was cold and uncaring if I remained silent when she was distressed, when I refused to hold her hand or actively sympathize with her difficulties, and the like. At the same time, I felt positively toward this patient and did find the therapy rewarding...I by and large did not feel cold and rejecting. There was much evidence in the therapy that the patient's perceptions reflected a sort of generalized transference, i.e., they accurately captured some of the early deprivations with mother which were inaccurately repeated and projected in current relationships in general. At the same time the patient and I were able to form a sound working alliance early in the therapy and I always had the sense that there was more strength in this person than she was able to accept, e.g., she was very bright and perceptive as well as insightful and hard-working; her coping skills in a variety of situations were quite good. Thus, I felt she had the strength to struggle through her demands for support and come to grips with and resolve some of the deeper conflicts that generated many of her symptoms. In essence, while I was acutely aware of this person's wish for direct support, I had the enduring sense that she could get more from therapy. A turning point in the therapy, occurring toward the end of the second year and corresponding with considerably improved functioning outside therapy, was the patient's expression of a belief that I was being empathic with her but she was only beginning to be able to "receive" the empathy she so intensely sought.

Offenkrantz and Tobin (1974), in discussing some principles of psychoanalytic therapy, shed light on how the therapist might proceed when he/she judges that the patient wants but does not need certain gratifications. They point out that many patients respond to the permissive atmosphere of therapy with an upsurge of dependency longings not accompained by the usual shame but only by frustration when the longings are not gratified. Here it is very important for the therapist to acknowledge openly the unusual quality of the treatment situation and the special relationship with the therapist that makes many kinds of difficult and intense feelings inevitable. It is crucial that

the therapist empathize with the frustration the patient feels when these demands are not gratified. If, however,..."the dependent demand for explicit gratification continues, the indication is for the therapist to direct the inquiry toward a different time and place in the patient's life, which is the first step in making a transference interpretation (p. 597)."

A rule of thumb here is that direct gratifications should be provided only when they are really "needed" by the patient. "Need" occurs when the therapist judges that fragmentation would occur without the direct support (or some other state that is deleterious to the organism) and/or when the therapeutic or working alliance between the therapist and patient would be seriously damaged by the lack of gratification.

The Proper Therapeutic Stance

Implicit in this paper so far is that there is a proper therapeutic stance or posture with respect to gratification and issues surrounding it. Explicitly, the second rule of thumb is that the most effective and workable stance is to gratify as little as possible. Thus, the central task of the therapist is to help the patient understand, make decisions, uncover, etc.; the more the patient can do this on his/her own, without direct support, the better. Gratifications are best viewed as departures (parameters in the psychoanalytic sense) that may at times by necessary and/or helpful. When gratifications are given, it is important that eventually the therapist and patient explore their meaning in terms of the patient's needs, deprivations, etc. It is also important, in this respect, that such an exploration be well-timed, and timing here usually means delaying until the emotional peak or crisis that stimulated the demand subsides. Examining the basis of the demand too soon

can be, and usually is, insulting to the patient...it defeats the very purpose of the gratification (i.e., it takes away the needed support, disrupts the working alliance it was intended to enhance).

The suggested stance implies that non-gratification should be the baseline in therapy, and that departures from it, i.e., gratification, should be justified. Might this posture lead to therapy that is too non-gratifying? Two factors militate against such an occurrence. First, it must be clear that a "gratifying atmosphere" needs to pervade the therapy, even though direct gratifications are withheld or given carefully. By "gratifying atmosphere" I mean the establishment by the therapist of a climate of trust, acceptance, empathy, respect, etc. These relationship variables need to be present in therapy of any theoretical persuasion, although the specific manner in which they are manifested would vary according to the therapist's persuasion, e.g., the client-centered therapist may show empathy by consistent level 3 and 4 reflections (ala Carkhuff, 1969), while the analytic therapist may do so by a properly timed transference interpretation.

A second factor militating against the suggested therapeutic posture's leading to a "too non-gratifying" therapy is related to the kinds of people who gravitate toward the therapy profession and the nature of the current training they receive. Ample evidence exists to indicate that people who seek advanced training in counseling and psychotherapy have strong needs to nurture and take care of people (Grater, Kell & Morse, 1961; Patterson, 1967). In addition, training programs in therapy (at least in psychology) usually do not provide a thorough grounding in psychoanalytic theory and therapy. Thus, most doctoral students have not even heard of Freud's rule of abstinence, and current training conventions suggest that "good ways to be" as a therapist are

to be active, spontaneous, feelingful, self-disclosing, etc. When these in vogue training conventions are implemented with trainees who have strong needs to help and take care of people to begin with, it becomes implausible that the suggested therapeutic stance would foster therapeutic behavior that is too ungratifying, withholding, cold, etc.

The Softening Phase

I have said that the appropriate therapeutic stance entails gratifying as little as possible, and that the baseline or frame-of-reference should be reflected by a non-gratifying posture. In a sense, this position is consistent with Freud's rule of abstinence. Unfortunately, like that rule the position says little about the conditions under which gratification is and is not desirable. One such condition is a function of the temporal point of the given therapy experience. That is, it is often crucial that the earliest phase of a therapy experience be more gratifying than later phases and than the therapist's general style would reflect. Thus, the rule of thumb here is that a softening phase is often vital to the establishment of the kind of working alliance that allows the patient to undergo later deprivations and not prematurely terminate or stalemate the therapy.

Probably all of us have heard horror stories from patients about therapy experiences where the therapist responded at an absurdly minimal level right from the beginning of treatment. The patient here feels he/she is getting nothing from an uncaring observer. My impression is that in most such cases the therapist was inappropriately employing a stance early in treatment that may have been productive later on, e.g., after the working alliance was "cultivated" by such gratifying behaviors as making periodic suggestions, saying things that clearly conveyed caring/liking, giving reassurances, etc.

During this early (usually earliest) phase many patients seem to require a lot of gratification, more than the therapist is comfortable in giving. While this is often a reflection of the severity or degree of pathology, that is not necessarily the case. For example, some people have a good bit of mistrust for the therapy enterprise itself (and there is much in our culture that stimulates such mistrust) without being deeply disturbed paranoid personalities and the like. Others have never learned that introspection, which is partly but necessarily painful, is a possible road to improved health. For still others, certain gratifications are required early so that the patient builds up a sense of confidence in the therapist's good will and competence. It is important to note, however, that such confidence is not established by the therapist being too gratifying. What is required is a fine line, one that the therapist "intuits", "senses", etc., as well as understands through diagnostic data. Finally, certain types of psychopathology (regardless of severity) may require more early gratification than others. For example, patients suffering from neurotic depression and/or those with a chronic depression-proneness seem to need much gratification in this period if they are to stay with the therapy.

As mentioned earlier, some therapists (e.g., Kopp, 1973) believe that in the earliest phase of treatment it is important to "be where the patient ain't". This stance is taken by the therapist in an effort to counter the patient's pathological style of being or relating. While the "be where they ain't" phase is probably appropriate at some point in the therapy, with many patients it is ineffective or damaging to begin the treatment with this tack. The need to "soften 'em up" before you "be where they ain't" increases as we move away from working with "healthy neurotics" who begin therapy with quite positive attitudes toward the value of the enterprise and with what might be called a

positive preformed transference to the therapist. The latter occurs when the patient determines whom his/her therapist will be, especially when a highly visible, well-known therapist is selected. This constellation is manifest most commonly in private therapy. It is notable that the bulk of "everyday therapy" is not private, however, but is done in agencies. Patients are less often "healthy neurotics" (in other words, ideal patients...young, attractive, verbal, intelligent, sensitive, not too disturbed, and with values similar to their therapist's); and their therapist is assigned on a random basis with the patient having no advanced knowledge of or choice in whom the therapist shall be. To reiterate, under such conditions it is often crucial in the earliest phase of the therapy to work hard at cultivating a working alliance, and an important ingredient of such cultivation is the provision of more direct gratification than is desirable as a general tack in the treatment.

In a sense, what I am advocating with some patients is a sort of "pre-therapy" phase where the therapist may need to gratify a great deal (even go against his/her grain) to "get things going" and stimulate the patient's feeling that the therapist is "on his side." What needs to be added here is that this softening phase cannot last forever if the therapy is to go beyond being strictly supportive work.[4] At some point the therapist must begin "giving" less, and this usually is a difficult time for the patient (as well as the therapist). It is a good idea to discuss frankly this change with the patient, since the change often stimulates feelings of confusion and rejection. My observation is that when the "withdrawal" of gratification (it need not be abrupt) is well thought out by the therapist it seldom creates serious problems and itself often generates important grist for the therapy mill.

Beyond the Early Phase: A Two-Dimensional Diagnostic Scheme

What about gratification beyond the softening phase? It is proposed that even after that phase, which may last from a few minutes to months, the extent and type of direct gratifications provided are critical moderators of outcome. The points made earlier with respect to differentiating wants and needs, and the proper therapeutic stance apply also to work beyond the softening phase. While a wide range of specific factors determines whether particular gratifications should be given, I suggest that two general factors shape or should shape therapists' gratifying behavior. These are (a) the severity of the patient's disturbance, and (b) the infantileness of the particular demand being manifested by the patient.

Severity of disturbance is a highly generic factor itself subsuming two constructs. The first is a characterological construct and the second a combined situational and characterological one. The first construct reflects the patient's overall "ego strength." Ego strength has at once been a crucial variable in personology (especially in psychodynamic theories) and an ill-defined, variously defined, or undefined abstraction. Here I am accepting Barron's (1953) definition: ego strength reflects the person's degree of contact with reality and sense of personal adequacy, his/her psychological flexibility and coping ability, and his her capacity for spontaneity. The combined situational-characterological construct is the "intensity of anxiety" experienced at a given time. This construct is characterological for obvious reasons; it is situational because situations external to the patient usually at least partly determine it. Thus, the patient may be in a crisis state (intense anxiety) due to loss of an external object, rejection in a work situation, etc. Now, these two constructs are juxtaposed such that they form a quality

or factor, here called severity of disturbance, that is a crucial determinant of the appropriateness of a given gratification and the degree of gratification in general in a given therapy experience.

Stated simply and linearly the rule of thumb is that the greater the severity of disturbance the more appropriate it is to provide direct gratification of dependency and affectional needs. This rule applies both to moment-to-moment decisions regarding particular gratifications and to the overall tenor of the therapy. Thus, "being gratifying" is more appropriate with patients who are severely disturbed, either due to situational crises or characterological issues, than those who are less. It is notable in this respect that classical analysis has been viewed by analysts, including Freud, as the treatment of choice for "healthy neurotics", and a recent observer of outcome research in analysis (Strupp, 1973) suggests that one of the reasons that such research has not placed psychoanalysis in a favorable light is that patients have not been carefully enough selected.

Freud (1916, 1917) suggested that mental disorders could be dichotomized into the transference neuroses and the narcissistic neuroses. By the former he meant the conventional neurotic disorders. The narcissistic neuroses, however, subsumed disorders such as schizoid and borderline personalities, and psychosis; Freud viewed these disorders as not treatable by analysis, and most current analysts appear to agree (cf. Greenson, 1967). That is not at all to say, however, that psychoanalytically-oriented or based approaches are inappropriate with these patients. Why has classical analysis been considered inappropriate for the more severe disturbances? The answer is highly connected to the above rule of thumb; this treatment, above all others, attempts to deprive patients of direct gratification from the analyst in an effort to promote depth

insight. The "narcissistic neuroses", the more disturbed individuals, tend not to improve without the same kind of gratification that inhibits deeper insight. An important point of this paper, and one consistent with those advocating modified analytic approaches with more disturbed patients (e.g., Kernberg, 1975; Kohut, 1971; Wolberg, 1973), is that we need not, on the other hand, "settle" for the strictly supportive approach that Freud recommended (that might last the patient's and therapist's lifetimes, it might be added). One can be much more gratifying than the classical analyst, but not so gratifying that crucial deeper insights are precluded.

The issues discussed in the above paragraph pertain mostly to the characterological aspect "of severity of disturbance", ego strength. The second aspect of "severity of disturbance" was labeled intensity of anxiety, and it was viewed as having a strong situational as well as characterological component. In the therapy of most patients, regardless of their level of ego strength, crises occur that stimulate at least moderately intense anxiety. Here again, the greater the crisis/anxiety the more desirable it is to provide direct gratification. It must be added that I am not advocating that the therapist should take a gratifying stance during all or nearly all crises with his/her patients. At times, paradoxically, that would be destructive; what is needed is for the patient to work through the crisis and understand how and what he/she has contributed to it. This is especially applicable to patients whose lives reflect repeated crises. The point is that intense anxiety and corresponding crisis situations are indicators that gratification may be appropriate.

The second generic factor that determines the appropriateness of gratification was labeled the <u>infantileness of the affectional and/or dependent demand itself</u>. It will be recalled that the term demand is being used as a shorthand

term encompassing such inner states as needs, wants, wishes, expectations, etc. This term is also used because at the deepest level these states most often represent demands of the organism. The position here is that dependent and affectional demands exist along a continuum, ranging from highly infantile to mildly infantile. Some degree of infantileness always exists, since (a) the demands represent a striving to get something from the therapist other than that which is part of the legitimate and explicit contract, i.e., the therapist and patient never contract for the former to give love to and take care of the latter; (b) the strivings are rooted in the patient's earliest and perhaps most profound experiences and deprivations (of the needs to be loved and taken care of).

A particular type of demand also may be viewed as existing on a continuum, from mildly to highly infantile. For example, the wish to have one's hand held versus that to be cradled in the therapist's lap. Also, requesting a periodic extra appointment during an emergency situation is much less infantile than requesting such appointments whenever one feels the urge. Additionally, demands for physical (i.e., developmentally pre-verbal) gratifications tend to be more infantile than those for verbal gratifications.

The simple, linear rule of thumb for this factor is that <u>the more infantile the demand the less appropriate is its gratification by the therapist</u>. Experience suggests that this rule of thumb is not a very powerful one in and of itself. It is most potent as it <u>interacts</u> with the severity of disturbance factor. Thus, in the experimental design sense, the appropriateness of gratifying demands at a given level of infantileness <u>depends</u> on the patient's degree of disturbance. This sort of interaction notion is exemplified by the following contingency table.

Insert Table 1 About Here

The table indicates that when we have patients who are very disturbed, and at the same time are "pulling for" direct gratifications that are not very infantile, the rule of thumb is to provide gratification. The converse is true, however, with patients who are not very disturbed (i.e., good ego strength, low or moderate anxiety-no crisis) and are "pulling for" highly infantile gratifications.

A few points regarding the table require elaboration. First, the question marks underscore the lack of exhaustiveness of our two factors to determine whether the therapist should give this or that. Whether or not to gratify is a deeply complex topic; while the two factors are important indicators, they only answer some of our questions. Variables having to do with the specific situation of the particular patient with a given therapist really provide "answers" to the cells containing question marks. Low level generalizations (those that account for a modest proportion of the variance in our criterion) and low order interactions (only two factors in this case) are best viewed as starting points in mapping psychotherapeutic terrains. A second point is that while such a two way classification may provide useful rules of thumb, there is no intrinsic reason why the continua should be sliced into only two levels. Such artificial slicing is one way of appropriately simplifying phenomena, but we do pay a price in the process, e.g., nonlinear relationships are masked by two level classifications.

Some Research Evidence

What light does research shed on the phenomena discussed in this paper? It goes without saying that a therapist can provide too much direct gratification of dependency and affectional demands. Virtually all theoreticians

would caution against, for example, always or nearly always giving advice or reassurance when the patient manifests implicit or explicit demands for such. Thus, we have a clinical axiom...a universally accepted principle based on a history of clinical observation. A question that is more open to debate, and a more researchable question, centers on whether the therapist should provide any direct gratification, and how important is this to the success of therapy. Two recent clinical studies do provide some tentative and affirmative answers to these questions.

A recently completed 20 year study at the Menninger Clinic (Horowitz, 1974) yielded results that ran heavily counter to the classical psychoanalytic ethos of that institution. Thus, in essence, the Menninger group expected that durable personality and behavior change would only result from the uncovering of core unconscious conflicts (structural changes in the ego, in their terms), and at the outset of their study little expectation was held that supportive aspects of therapy and analysis would produce permanent changes. To their surprise, the supportive or need gratifying aspects of therapy appeared to be vital and related to durable changes two years after therapy terminated. This finding was striking enough to stimulate a revision of some vaunted psychoanalytic hypotheses about how durable personality change occurs in therapy. In essence, as a consequence of the research data, direct gratification (Horowitz presents examples of very direct advice giving and counsel, reassurance, and moreover, very overt parenting behavior on the part of the therapists and analysts) was viewed as appreciably more important, especially for the more disturbed patients, to the outcomes of therapy and analysis.

A second study is perhaps more significant because of the more heterogeneous patient and therapist sample, as well as treatment procedures (ranging from classical analysis on a private basis to once-a-week therapy of only six

month duration done at an outpaitent clinic). Strupp, Fox and Lessler (1969) found that what was referred to earlier as a gratifying atmosphere (empathy, warmth, respect, attentiveness, etc.) was quite important to patients' feelings that their therapy was successful several years after termination. This has been a fairly consistent research finding across a variety of therapies (e.g., Rogers, Gendlin, Truax & Kiesler, 1967; Truax & Carkhuff, 1967). A less obvious result reflected the importance of direct gratification. For example, patients' perceptions that therapists almost never gave direct reassurances and were highly passive, and patients' uncertainty about the therapists' real feelings toward them, were negatively related to variables noted above as crucial in establishing a gratifying atmosphere (again, variables, in turn, related directly to outcome). Even more to the point is the researchers' summary, as follows, of important therapist factors in outcomes:

> The composite image of the "good therapist" drawn by our respondents is thus that of a keenly attentive, interested, benign, and concerned listener - a friend who is warm and natural, is not adverse to giving direct advice, who speaks one's language, makes sense, and rarely arouses intense anger. This portrait contrasts with the stereotype of the impersonal analyst, whose stance is detached, who creates a vacuum into which negative as well as positive feelings can flow, and who maintains a neutral though benign role., more a shadowy figure than a "real" person. (Strupp et al., 1969, p. 117; italics added)

What the Menninger and the Strupp et al. investigations seem to tell us is that direct gratification is an important aspect of successful therapy. It is a more important ingredient than had been previously acknowledged by therapists of a psychoanalytic persuasion, and probably of other evocative or expressive orientations. Going a bit further in interpreting the data, the Menninger

study appears to support the value of one of the rules of thumb proposed in this paper, namely, the greater the severity of the patient's disturbance the more appropriate it is to gratify dependent and affectional needs. That is, the more disturbed the patients in that study, the more likely were the therapists to employ supportive procedures...and the more successful was the therapy thus judged to be by patients and independent raters. Finally, an examination of the pattern of correlations and the authors' observations in Strupp et al. suggests that the univariate and linear relationship of variables tapping what I call direct gratification and outcome is but a modest one. As implied earlier in this paper, we are dealing with complex questions that may only be "answered" by higher order interactions, and the correlations between indices of direct gratification and outcome are usually not simple, linear ones. Future empirical and theoretical inquiry needs to address itself to such complexities. Some of the proposals, i.e., rules of thumb, in the present paper are legitimate starting points.

In the event that it is not entirely clear, the research discussed above in no way implies that since direct gratification seems to be a good thing the more of it that is given the better. Consistent with the premise of this paper, the best interpretation of the research is that the patient must perceive at least a modicum of gratification (varying with the phase of the therapy, the particular patient and problem situation) for the therapy to be as successful as possible. Rigorous and consistent therpist abstinence probably is more theoretically sensible than practically sound.

Conclusions

I have suggested that in nearly all therapy cases the patient exhibits demands for gratification of dependent and affectional longings. The manner in which such demands are responded to by the therapist is crucial in determining the nature and, indeed, the success of therapy. The therapist can

"give" too little or too much, and each of these errors contains a cost. By way of summary, the paper presents several rules of thumb that should help guide therapist gratifying behavior. These rules focus on (a) differentiating between patients' needs and wants; (b) a proper therapeutic stance vis-a-vis gratification; (c) the use of gratification in the early stage of therapy; (d) patient characteristics (severity of disturbance and infantileness of demands) moderating the appropriateness of gratification throughout therapy.

Research has only touched the tip of the iceberg regarding this complex question. At least two major studies appear to indicate that direct gratification is more important and desirable than has been assumed by the evocative, insight oriented therapies. We know little if anything to date, through research, about the conditions under which a given type of gratification is helpful with a particular kind of patient in this or that type of therapy.

There are a number of important issues revolving around gratification that have not been illuminated in this paper. While space limitations do not permit elaboration, I would like simply to state certain of these issues in the form of generalizations or hypotheses that warrant further exploration: (a) It is the phenomenology of the patient that ultimately determines whether any given therapist response is gratifying or not; (b) Often the process of gratifying one patient need (e.g., for aggression) itself results in the frustration of a complementary need (e.g., for affection); (c) At times a patient may both want and need certain gratifications that the therapist simply is unable to provide, e.g., the patient may want and need the therapist's ongoing presence for a substained period of time, while the therapist's life situation, etc. precludes that; (d) Some patients never get "enough" gratification, just as some patients are untreatable; (e) In contrast to the psychoanalytic tenet that a

given need must be frustrated (rather than gratified) for it to emerge into consciousness, at rare moments direct pratification itself stimulates insight (an exception that proves a rule?)

If there is a moral to the present story, it is that orthodxy will not help us answer the complex questions explored in this paper. The humanistic orthodoxy which suggests the therapist should be spontaneous, respond lovingly when he/she feels it, and the like just has too many pitfalls. So does the analytic orthodoxy that implies that the therapist should be rigorously abstaining in a effort to promote depth insight. We can neither abstain at all costs nor act out whatever we feel.

Table 1

Contingency Table for Gratification

Severity of Disturbance	Infantileness of Demand: High	Infantileness of Demand: Low
High	?	+
Low	-	?

Note: The plus sign indicates that gratification is appropriate, the minus sign that gratification is inappropriate; the question marks indicate that the two factors are not sufficient to dictate a given stance *vis-a-vis* gratification.

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Footnotes

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[2]While the areas of dependency and affection are the foci of this paper, it is acknowledged that other types of needs emerge and seek gratification in the therapy, e.g., masochistic needs, aggressive needs, needs for attention.

[3]The term demand shall be used throughout this paper as a generic term encompassing such states as expectations, wishes, etc. The term demand has been selected as a simple shorthand term and because it probably captures better than other terms the deeper emotional state of the person. Thus, when the patient "pushes for" affection and/or nurturance, it usually turns out to be a demand upon deeper examination.

[4]This is not to say that a strictly supportive therapy is not legitimate. At times it is the only viable approach e.g., when the patient is simply unmotivated for work beyond support, when only a brief amount of time is available, when the costs of longer-term work are prohibitive, when there is a chronically psychotic picture, when the agency promotes brief supportive work because of long waiting lists.